CENTER FOR HOPE AND HEALING
660 E. Franklin Rd., Suite 260
Meridian, ID 83642
Voice: (208) 343-0441 • Fax: (208) 343-4993

MEDICARE OPT-OUT AFFIDAVIT

I, _____ (Therapist), being duly sworn, depose and say:

1. I promise that, except for emergency or urgent care services (as specified in 42 C.F.R. §405.440), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of 42 C.F.R. §405.415 for services that, but for their provision under a private contract, would have been Medicare-covered services.
2. I promise that I will not submit any claim to Medicare for any item or service provided to any Medicare beneficiary during the 2-year period beginning on the following effective date: April 1, 2011 ; nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in 42 C.F.R. §405.440.
3. I understand that, during the opt-out period, I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare + Choice plan.
4. I acknowledge that, during the opt-out period, my services are not covered under Medicare and no Medicare payment may be made to any entity for my services, directly or on a capitated basis.
5. I promise that during the opt-out period I will be bound by the terms of both this affidavit and the private contracts that I enter into with Medicare beneficiaries.
6. I acknowledge that the terms of this affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by me during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.
7. I understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of 42 C.F.R. §405.440 apply if I furnish such services.
8. I acknowledge that my Part B participation agreement terminates on the effective date of the affidavit.

_____
Signature of Therapist

_____
Printed Name

_____
Principal Office Address

_____
City, State, Zip

_____
Telephone Number

_____
National Provider Identifier (NPI)

_____
Medicare Provider Identification Number, if
one has been assigned (UPIN or PTAN)

_____
License Number(s)

_____
Tax ID Number

STATE OF _____)
) ss.
County of _____)

Sworn to and subscribed before me this _____ day of _____, 2011

_____
Notary Public for Idaho
Residing at _____
My commission expires _____

Two copies of this affidavit should be completed—one must be filed with your medicare carrier (sent by registered mail, return receipt requested) and the other should be kept on file in your office.

Please send your opt out request to :

CIGNA Government Services
Provider Enrollment Department
P O Box 25226
Nashville, TN 37202-25226